MDR Tracking Number: M5-04-2857-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 05-04-04.

The IRO reviewed office visits, myofascial release, hot/cold packs, electrical stimulation-unattended, ultrasound, therapeutic exercises, diathermy, electrical stimulation and manual therapy technique rendered from 05-05-03 through 09-25-03 that were denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-09-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99080-73 for date of service 08-27-03 denied with denial code V. This is a TWCC required report and not subject to IRO review, therefore service is reviewed as a fee issue. The respondent raised no other reason for denial, therefore reimbursement is recommended in the amount of $15.00.

This Findings and Decision is hereby issued this 30th day of August 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 05-05-03 through 08-22-03 in this dispute.

This Order is hereby issued this 30th day of August 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 9, 2004

RE: AMENDED DECISION
MDR Tracking #: M5-04-2857-01
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Table of disputed services; DOS from 5/05/03 up through 9/25/03.
- Assorted EOB's for DOS from 5/05/03 up through 9/25/03.
- Medical dispute resolution form request from _____.
- Assorted medical records, daily notes from _____.

Submitted by Respondent:

- Table of disputed services; DOS from 5/05/03 up through 9/25/03.
- Assorted EOB's for DOS from 5/05/03 up through 9/25/03
- Assorted TWCC dispute forms, including TWCC-60 (no date noted) and TWCC-73 dated 5/26/04 by _____.
- Peer review by _____ dated 10/21/03.
- Peer review by _____ dated 2/05/04.
- Assorted medical reports and post surgical follow-up reports by _____ dated 8/26/03 (joint injection) and 5/11/04 (right knee arthroscopy).
- Legal representation letters from Attorney _____, dated 5/27/04 and 6/17/04 and 5/27/04

Clinical History

The claimant allegedly received injury to the right knee region due to the work related slip-and–fall incident dated ___ while performing occupational duties for his employer.

Initial care was administered by _____ in the emergency room on ___ and was placed at light duty.

The MRI performed on 7/01/02 revealed a bucket-handle tear to the medial meniscus.

Surgical referral to _____ on 7/16/02 resulted in surgery performed on 8/13/02, which caused post surgical complications, diagnosis hematoma, with re-evaluation with _____ on 9/04/02 revealing continued pain and clicking, lead to a referral for bone scan, which is noted as performed on 9/27/02.

Recommendations for physical therapy, via chiropractic conservative care, with _____ dated 11/12/02, resulting in numerous referrals, second opinions evaluations, and repeat MRI performed on 1/10/03, the claimant still continued to complain of the same symptomatology.

Therefore, a second arthroscopy procedure is noted as 2/19/03 performed by _____ and post-op rehab, physical therapy via chiropractic conservative care again, with _____.

Also noted, in 8/03 a FCE was said to have been performed, however unavailable for this review.

A bone scan was again performed, due to the continued symptom claimant complaints on 9/30/03 revealing right knee abnormalities; increased uptake, suggesting post-traumatic or post-surgical increased uptake.

Since no real improvement has been experienced by the claimant, recommendations for MMI and permanent impairment were recommended.

RME performed by _____ on 10/21/03 suggested a designated doctor exam be performed, since he anticipates that a third surgery would not benefit the claimant further, additionally denoted finding the claimant at a stationary and stable point in recovery, therefore suggesting MMI on or about 6/01/03.

The final document for review was a peer review from _____ dated 2/05/04, who felt any further chiropractic care would be unnecessary, due to the unsuccessful attempts to correct and heal the injury area, in respect to the 2 prior surgeries, and that a third would not benefit, in the same respect. The doctor also noted that the claimant appeared to be at MMI and suggested that the claimant be placed there. Additionally, if a third surgery would be performed that post-op therapy/chiropractic care would be reasonable and necessary, however, per last avail chart notes dated 1/02/04 through 1/07/04, “nothing is working” per the doctors’ written report, in respect to this claimant’s recovery process.

Requested Service(s)

Please review and address the medical necessity of the outpatient services; 99212/99215-office visits; 97250-myofascial release; 97010-hot/cold pack; 97014/G0283–electrical stim–unattended;

97035–ultrasound; 97110-therapeutic exercise; 97024-diathermy; 97032-electric stim; and 97140-manual therapy technique for dates of service (DOS) from 5/05/03 thru 9/25/03

Decision

I disagree with the insurance company and find the necessity for treatment/service regarding the following E/M codes; 99212 on 5/05/03, 05/19/03, 6/05/03, 6/20/03, 7/03/03 and 7/24/03; code 97250 – (myofascial release); 97010 (hot/cold pack); 97014 / G0283 – (electrical stim – unattended); 97035 – (ultrasound); 97110 (therapeutic exercise); 97024 (diathermy); 97032 (electric stim); and 97140 (manual therapy technique) on 5/05/03, 5/12/03, 5/19/03, 5/29/03, 6/12/03, 6/20/03, 6/27/03, 7/03/03, 7/11/03, 7/18/03, 7/24/03, 8/01/03, 8/08/03, 8/14/03, 8/22/03, 8/29/03, 9/05/03, 9/12/03, 9/19/03, 9/25/03 were medically necessary.

I agree with the insurance company and find that the following E/M codes were not medically necessary for the DOS 5/05/03 thru 9/25/03 (excluding those dates listed above); code 99212 (office visit), 99215 (office visit), 97250 (myofascial release); 97010 (hot/cold pack); code 97014 / G0283 – (electrical stim – unattended); 97035 – (ultrasound); 97110 (therapeutic exercise); 97024 (diathermy); 97032 (electric stim); and 97140 (manual therapy technique).

Rationale/Basis for Decision

After thorough review of documentation from both presenting parties, it is my opinion, based on current treatment guidelines in the medical and chiropractic community, subjective and objective findings in this case and with input from secondary examining physician reports that this claimant did require an extended timeframe for continued rehabilitative care beyond the usually 12 week post rehab timeframe. There were extenuating factors; based on solid objective testing (verified by MRI / bone scan) and reported on numerous occasions that this claimant may require further surgical repair following the second event. I do agree the claimant did not demonstrate significant progress gain throughout the first 12-week session, however, there were apparently, at least one, if not other attempts, to return to gainful employment within the timeframe in dispute.

Based on the possibility of another follow-up surgery alone, is sufficient reason for continuation of some form of rehabilitation (at least in part). If not to further gain then, at least maintain what is already there. This is a reasonable and customary (and logical), step in terms of pre-surgical treatment for overall improved post surgical outcome and based on the failure of two previous surgical events, it would seem more important, especially in this case, that this is appropriate treatment, although, the frequency at 3 times per week does not appear reasonable or necessary for maintenance purposes.

Another reasonable and necessary rationale is that this claimant demonstrated secondary arthritic changes, post surgically, and a continued active type program, in most cases, would be beneficial, especially if this claimant required another surgical procedure, which evidently was the case. I might point out that this claimant was determined not to be at an MMI status, per designated doctor exam, which holds more weight in terms of examining physicians, although, not always in agreement with the reports, I do find that in this case, it did appear accurate.

I would also point out that, this was probably the best route for a claimant with two post-surgical events who, more than likely, would not have accomplished or maintained as much if only utilizing a self-administered home exercise program.

In conclusion; if not for the possibility of a third surgical event, the objective arthritic findings and some attempts to return to work, I might otherwise find that this treatment was not reasonable or necessary (or supported), especially in light of no significant, objective lasting improvement, although, it is my opinion, that these extenuating factors, do provide enough rationale for rehab therapy continuation, in this case.

In terms of office visits; since this is an extension of physical therapy with out any major changes in protocol/routine, office visits (99212) at 1-2 times per month are reasonable to oversee this process.

Concerning office visits (99215); I found no support in the documentation provided for this review that supported its necessity within this timeframe.

In addition, this therapy continuation was more towards maintenance (maintaining) and not progressive, and since the possibility of another surgical event was evident, then therapy should have decreased in frequency. With the claimant already benefiting from 12-weeks of therapy, prior to dates of service in question and progress was not demonstrated; logically a decrease is reasonable for maintenance only, while decisions for another surgery were being made. Rehab therapy at 1 time per week, is reasonable to accomplish this with the claimant participating in a well instructed home exercise program, on days when not scheduled for clinical therapy.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the patient, the requestor, the insurance carrier, and TWCC via facsimile or U.S. Postal Service from the office of the IRO on this 9th day of August 2004.